

AIDS legislation – turning up the heat?

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Author's abstract

This paper is not about the medical condition of AIDS. Nor is it about the history of the condition since it was first reported in Atlanta, Georgia in 1981. It looks rather, at the catalogue of legislative and other legal responses to the spread of AIDS.

The paper analyses the AIDS condition in its historical context. The hysteria accompanying the outbreak of AIDS is contrasted with the similar hysteria associated with other previous epidemics experienced in Australia over the past two centuries.

The paper categorises the responses of lawmakers to the condition, according to the approach taken; from 'full blast', through 'moderate heat' to 'low key' or an attempt to avoid or minimise legal intervention. It is suggested that the appropriate response should depend upon such factors as the present magnitude of the condition, its likely future course, the availability of cures and protections against its spread and objectives being sought by intervention. Unless these factors are taken into account gross over-reaction can occur, causing social disruption and much personal injustice.

This paper is based on a speech delivered at the Commonwealth and Victorian Health Department's National Conference on AIDS, in Melbourne on the 16th of November 1985. The views expressed are purely personal.

Lessons from the past

Acquired Immune Deficiency Syndrome (AIDS) is not a single disease but a lethal condition of risk. The AIDS virus attacks and disables the immune system of the human body. It destroys the cells which normally protect the body against infection. A patient with this condition is therefore vulnerable to a long list of 'opportunistic' infections which the immune system would normally be able to rebuff without harm. The median survival of patients diagnosed as suffering from 'Category A' AIDS is about one year. The virus has been found in blood, semen, saliva and tears. It is

infectious but, as compared to earlier infectious diseases, AIDS is relatively hard to contract. Almost exclusively, the condition is spread by exchange of bodily fluids through sexual relations or by sharing of intravenous needles. The overwhelming proportion of reported cases of AIDS in Australia, as in other countries, fall into well identified groups: homosexuals, bi-sexuals, haemophiliacs and intravenous drug users. The identification of these groups has affected public and legal reaction to AIDS. It has heightened fears and promoted legal and administrative responses which are said to involve discrimination and prejudice rather than compassion and prevention.

The introduction in November 1985 into the New South Wales Parliament of the *Public Health (Proclaimed Diseases) Amendment Bill 1985* demonstrates that specific legislation on AIDS has reached Australia. The purpose of this paper is to review the legislative and other legal developments proposed or reported in Australia and other Western countries. But first it is appropriate to place the isolation of the AIDS condition into an historical context.

No lawmaker or bureaucrat should approach the drafting of Australian laws on AIDS without reading the recent book by P H Curson *Times of Crisis* (1). The book outlines the history of six epidemics which occurred in Sydney, starting with a smallpox outbreak in 1789 and finishing with a smallpox epidemic in 1881 and an outbreak of bubonic plague in 1900. The author notes in his preface the interest in the 'upsurge of hysteria and panic' in AIDS and compares it with earlier such instances. From the very beginning of Australia's history, our people have been familiar with epidemics. On many of the convict boats bringing their human cargo to Australia, a third of the passengers perished from the spread of disease (2). But in the 19th century, disease was more stoically borne. There are many reasons for this. They include the deeper sense of religious fatalism which accompanied earlier outbreaks and the absence of the triumphs of medical science which has produced unbelief in our modern community that AIDS cannot be beaten with a pill or a shot of vaccine. Furthermore, although mortality was high in the case of plague, in the case of AIDS, the

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absence of any known cure and the virtual certainty of death in most fully developed cases of AIDS makes the condition more frightening to a community whose fears are enlivened by widespread media interest (3). In the 1881–2 smallpox epidemic in Sydney there was a similar community alarm. Nine hundred people were formally quarantined, 700 of them in ships off the coast (4). Conditions were primitive. Ultimately the government decided to build improved quarantine facilities at Little Bay (5). The Chinese were suspected to be the source of the outbreak. Their houses were burned down (5). They were made scapegoats. Trains leaving the colony of New South Wales were searched at Albury to prevent the spread of disease to Victoria (6). Political leaders began to talk of compulsory vaccinations for the whole population (7). The newspapers fanned public fears by articles on 'the Great Plague' (8). Does all of this sound familiar?

The outbreak of plague in 1900 caused even greater mass hysteria (9). Large areas of Sydney were closed off (10). Neighbours were encouraged to spy on neighbours. The Chinese, again, were subjected to virulent campaigns of abuse and isolation (10). The politicians reacted with quarantine arrangements. Large numbers of Chinese were forced to occupy tents on the beaches (11). Rat-catching squads were organised, private and public (12). The churches were crowded to overflowing on days of Humiliation and Prayer (13). Health officials of the time had to struggle against an unfortunate mixture of self-interest, ignorance, panic and over-reaction. The over-zealous policy of quarantine caused a great deal of personal and family tragedy and much business ruin (14). But some good came of it all. When the threat of plague disappeared, and no more cases were reported after 29 weeks, there was a beneficial public reaction. Calls were made for the reform of laws on public health (15). The need to improve the poor housing of the working class was generally recognised (14). In this way, a terrible event was turned to some good.

It is hard in Australia, at the time of writing, to see advantage coming out of the AIDS predicament. For people diagnosed, it is a personal tragedy and, often, a family crisis. It is stressful to health workers and others, particularly because the victims are often young, with much to live for. From society's point of view, it is doubly tragic. Just as our community was lifting itself out of the morass of primitive prejudice against homosexual men and women, AIDS appeared to fuel the flames of prejudice and to rekindle them, where it was hoped they had been extinguished.

Let there be no doubt that this melancholy result has occurred in Australia and in other like communities. A politician in the United States, at a meeting discussing AIDS did not know that the microphone was left on. His solution was 'shoot the queers' (16). Others, more temperate, in England, expressed the view that God had sent divine intervention to punish wickedness (17). Correspondents wrote to Australian newspapers contending that homosexuals were 'a cancer on society'

who refused to put 'blame where it belongs' (18). Attempts, in those remaining jurisdictions where laws punishing people for consensual acts of their sexual orientation remain on the books, to repeal and reform those laws provoke alarmist petitions expressing fear that any change in the law will reduce society's defences and encourage the spread of AIDS to the general population (19).

This paper is not about the medical condition of AIDS. Nor is it about the history of the condition since its first reports in Atlanta, Georgia, in 1981 (20). It is designed, instead, to provide a catalogue of legislative and other legal responses to the spread of AIDS. An attempt will be made to categorise the responses according to the approach that is to be taken: from 'full blast', through 'moderate heat' to 'low key' or an attempt to avoid or minimise legal intervention. Before venturing this task, however, it is important to have some idea of the extent of the problem. By November, 1985 it was reported that 7,418 persons had died of AIDS in the United States, half of them in New York. There were 14,393 confirmed cases. The figures were doubling every ten months (21). In Europe 1226 cases had been reported. At present there were said to have been 400 deaths in France, 250 in West Germany and 180 in the United Kingdom (22). One recent report suggests that the numbers of cases of fully developed AIDS diagnosed in Australia had 'slowed dramatically' and that earlier official estimates of 200 deaths by the end of 1985 and 600 by the end of 1986 now seemed unlikely to be borne out. The figures in November, 1985 were 134 category A cases, 57 deaths. In order to judge the nature of the legal responses that are appropriate to address any epidemic – whether smallpox, plague or AIDS – it is necessary to have some idea of its present magnitude, its likely future course, the availability of cures and protections against its spread and the objectives being sought by legal intervention. Unless lawmakers have these factors constantly before them, consideration of the history of earlier epidemics suggests that gross over-reaction can occur, causing social disruption and much personal injustice.

What, then, are the legal reactions that have been introduced or suggested as a means of coping with the spread of the AIDS virus?

Full blast: society's defences

EXTREMES OF FEAR

At the very extreme of irrational fear are those who write to the newspapers suggesting that AIDS should be used in *support* of the criminal justice system. I saw one letter, which should only be repeated to show the depths to which human passion can sink. It urged that AIDS be used to infect criminals, in order to reduce the criminal population. Short of this is the suggestion that there should be compulsory blood tests of the *whole* population and also travel restrictions to limit the travel of homosexual men to San Francisco and back,

for fear that they will introduce the virus or increase its prevalence in Australia. Such measures are justified and supported by reference to the need for society to build a wall and prevent the influx of danger. The difficulty is one of getting the balance right between effective control and excessive or unacceptable intrusion into personal freedom. How would such passengers be identified as they tumbled out of the jumbo jet, after the long haul across the Pacific? Unless every person coming from San Francisco was to be tested, how could you be sure? And yet some people travel around the world and, although they spend some time in San Francisco, return via London. Are they also to be tested? Why limit it to San Francisco? What about Los Angeles? What about New York? In short, the logic of this proposal requires either its abandonment or insistence upon compulsory testing of all immigrants. Yet some immigrants will be doubtless at risk from Australians rather than the other way around. And the cost of instituting tests at the airports or requiring tests overseas as a price for visas would be enormous. An equation is at work here. Would such a toll in cost and inconvenience, with the inevitable deterrent effect upon the tourist industry, be worth the limited protection secured? Does the magnitude of the problem justify such a reaction? Would only cases of fully developed AIDS be excluded? Would it seriously be suggested that a returning Australian with AIDS antibodies (who might or might not go onto AIDS) be denied entry to his or her native land? One has only to mention these difficulties with the proposal, to see the unacceptability of it. Yet it is doubtless put forward in all sincerity. And it draws upon similar reactions when ships were kept off the coast of Sydney during earlier epidemics, in the name of society's right to exclude potential contaminators.

UNIVERSAL TESTING

Another suggestion that has been made proposes universal testing. There are precedents in the law for such an approach. Compulsory x-rays for tuberculosis were required in New South Wales under the *Public Health Act* (23) and in other Australian States. Ultimately somebody did the sums and found that the incidence of tuberculosis was so low and the cost and actual risks of mass x-rays were so high that the problem did not merit the solution. Might it not also be so with AIDS? Where are the personnel who would administer national testing? What would be the utility of it? Unless it is proposed that all persons with AIDS antibodies be isolated, such universal testing would be disproportionately costly to the utility for public health purposes secured. Furthermore, 'passing' the test would be of limited use. The test might fail to show a very recently acquired exposure to the AIDS virus. It would certainly fail to show an exposure acquired immediately after the test. Unless everybody is to be tested constantly and repeatedly, the utility of testing would be hard to see. Its disutility would be enormous, quite apart from the cost and inconvenience. Evasion

and interference in the tests would almost certainly follow any endeavour to make consequences of quarantine flow from them.

NATIONAL ID CARD

Some commentators have suggested that the proposed 'Australia Card' would be an excellent data base for recording AIDS victims and those with Human T Lymphotropic Virus type III (HTLV-III) (the AIDS virus) antibodies. Certainly its universality would provide the convenient receptacle to record such data. But given the danger of public hysteria and prejudice, the price paid would be enormous and the efforts to disrupt and frustrate such a universal system would be then inevitable.

QUARANTINE

The demand has been voiced that homosexuals, at least those with antibodies, should be quarantined. It should not be thought that quarantine is unknown to Australia either. The record of the early epidemics show that it is a normal, if not typical, response to epidemic and pandemic diseases for society to seek to protect itself by isolating the victims. In the case of AIDS, the problems are those of identifying the sufferers and distinguishing the conditions from which they suffer. If all persons with HTLV-III antibodies were to be isolated enormous resources would be required because the number of persons with antibodies is likely to be now or shortly in terms of 100,000 or more throughout Australia. Where will we have the land? Where will we find the nursing staff? Given the demands on resources competing for government support, is it realistic to speak of such a response? Would it not be unjust to the 70 per cent and more of those with antibodies who will (for some reason that is still a mystery) not go onto AIDS? To isolate them would not only involve personal injustice and disruption to their lives. It would threaten them with stigma and discrimination. It would disrupt their families and dependants. It would have its ripple effect through the economy. Again, the balance between danger and reaction would be totally out of joint.

In short, for quarantine laws to be necessary and effective there has to be a coincidence of need and capacity. In the case of AIDS, the condition is relatively uncontagious (24). The numbers potentially at risk are enormous. There being no cure, the possibility of isolating a current victim and thereby containing the disease is, in practical terms, negligible. Effective measures are more likely to be directed with greater precision. Broad brush approaches are not only likely to be ineffective. They are likely to be so grossly expensive and disruptive (as well as unjust) that they would not be tolerated, at least at the present level of the condition. Nevertheless, it is interesting to note that in California consideration is being given to the state of the quarantine laws (25). If the worst fears concerning AIDS are vindicated, there will doubtless

be some in Australia who will revive talk of quarantine.

Moderate heat: strong measures

COMPULSORY DETENTION

Under English law, which we have inherited in Australia, every hour of human liberty is deemed precious. However, it is a measure of the concern about AIDS that, in 1984 the United Kingdom Parliament enacted the *Public Health (Control of Diseases) Act* 1984. It came into operation in respect of AIDS in March, 1985. As explained, the Act was intended for use in 'exceptional circumstances'. It allows for orders to be made for patients believed to have AIDS to be compulsorily medically examined. It also allows for AIDS patients to be removed to hospital and detained. Restrictions can be placed on the handling and removal of the body of an AIDS patient. The Minister assured Parliament that it was not intended to use the legislation against prostitutes. A news report in September, 1985 indicated that Manchester magistrates had granted an order detaining a 29-year-old AIDS victim in hospital for three weeks against his wishes. The patient was described as 'bleeding copiously from a large number of places'. The Chief Medical Officer felt that it was risky for him to leave hospital. However, a charity aiming to help AIDS victims said that it would fight the move in the courts:

'The spectre of being imprisoned in hospital may dissuade many people from being treated for the illness. It will cause enormous problems' (26).

Similar legislation to permit a chief officer, satisfied that there are reasonable grounds to believe that a person has AIDS or a related disease, to require that person to have a medical examination was proposed in New South Wales.

COMPULSORY REPORTING

Compulsory reporting of contagious and infectious diseases is a common response of the legal system, designed to achieve a number of objects. These include measuring the disease; judging its spread and distribution; determining its pattern and possible cure or prevention; ensuring treatment of victims and if treatment is impossible or unavailable, ensuring that they are warned and, if necessary, isolated. In a number of overseas countries AIDS has already been added to the list of notifiable diseases. Medical practitioners are required, by law, to notify it to health authorities in Denmark, Iceland, Norway and Sweden, in Hungary and in three Canadian provinces (British Columbia, Ontario and Saskatchewan) (27). It was reported that all States in the United States 'have or are intending to make AIDS a notifiable disease' (27).

The moves to require such notification by medical practitioners in New South Wales under the Public Health (Proclaimed Diseases) Amendment Bill 1985

have been justified on the bases just mentioned. However, the proposal as originally cast drew fire from a disparate but impressive group of opponents:

(i) The Council for Civil Liberties was reported as saying that compulsory reporting would have a 'chilling effect' on voluntary submission to tests because of the fear which the largest group of people vulnerable to AIDS (homosexuals and bisexuals) have that they will thereby bring upon themselves the status of a 'legal pariah' (23).

(ii) The Conference of Australian Labor Party (ALP) women opposed the proposal on the basis that it would deter potential victims from seeking medical advice, reassurance and guidance for fear of bringing themselves within the possible criminal offence of 'knowingly' passing on the disease. What you do not 'know' may sometimes help protect you from criminal responsibility (29).

(iii) Various commentators have pointed out that AIDS is one of the most 'gossiped about' conditions. Fear is expressed of leakage of the information about victims, with resulting loss of privacy, identification and discrimination. Thus, already within the homosexual community throughout Australia, pamphlets have been distributed titled 'Beware the Test!'

(iv) A number of lawyers have called to notice the fact that medical privilege is not as extensive as the privilege a lawyer confers upon his client. Although the law on medical privilege varies in different parts of Australia, in most States there is no absolute right of a doctor to refuse to reveal confidential information to a court (30).

(v) Dr N Blewett, the Federal Health Minister, suggested that compulsory notification might be 'counter productive' in turning away the very people who need to be identified (31). This point was also made by the New South Wales Privacy Committee which asserted that it was essential to guarantee confidentiality in order to fight the problem as an issue of public health (32).

(vi) A number of medical practitioners took their stand. Some threatened that they would be martyrs to the new law rather than comply with it (33). One doctor (Dr Tarlington) wrote to the *Sydney Morning Herald* in praise of the medical staff looking after AIDS victims and suggesting that threats of imprisonment and fines of such people were entirely ill placed (34).

SHUT THE CLUBS

As a consequence of these criticisms the measure was substantially amended before introduction to provide protections, including by court order against breach of doctor/patient confidentiality. A further proposal for strong action is now under way in the United States. By a vote of 416 to 8, the United States Congress recently approved the allocation of Federal funds to encourage the closure of homosexual clubs and baths (35). In New York, newly re-elected Mayor Koch took steps under health law to seek closure of one particular club which

was ignoring basic health precautions (36). Steps have also been taken in California. However, the courts have been resistant to the efforts to close such venues. Possibly this resistance has been based upon a belief that it is preferable to endeavour to promote safety by vigilance, in venues over which there is some control for hygiene, rather than forcing people 'under ground' to venues even more at risk (37).

In Australia, editorials have called for an examination of the closure of bath houses (38). The proposal has been opposed in the homosexual press (39) and by many commentators, on the basis that it would be counter-productive. It is a question of judgement. Will the spread of infection be stemmed in this way? Or will it actually be increased by the likelihood that sexual outlets will be sought in circumstances even more at risk than in baths where advice, condoms and that special enemy of the AIDS virus (soap and water) are available in plentiful quantities.

EMPLOYMENT

In the field of employment we are beginning to see employer responses. A recent report suggested that all British Airways stewards will now have to declare sexual orientation. This was said to follow the publicised discovery that a British Airways hostess had AIDS from an affair with a bisexual steward (40). An editorial which I recently read urged that society would not tolerate a typhoid carrier in a sandwich bar. So, it was said, society had a right to protect itself from AIDS victims in employment where they put others at risk. But the point made by the Australian National Task Force, a body set up by the Federal Government to investigate the implications of AIDS for Australia, and possible measures which can be taken to combat it, is that AIDS is not a particularly infectious disease. Save for intimate exchanges of body fluids, the likelihood of infection is negligible. In these circumstances, responses by employers requiring the loss of privacy of employees are likely to be of limited success. They may do disproportionate injustice and provide a reservoir of prejudice quite unnecessary for the protection of the employer's business, let alone the protection of the public.

PRISONS AND ARMED FORCES

People in disciplined situations are more susceptible to invasive investigation and therapy. It was so when the homes of the working class were subjected to compulsory carbolic cleansing during the epidemic in Sydney in the 1890s. It is so today in prisons and in the armed services. Already in the Northern Territory it has been announced that legislation will authorise the compulsory taking of blood samples from prisoners to identify AIDS victims (41). Similar testing of prisoners in New South Wales was estimated to cost \$1 million a year (42). It was said that US tests reveal that 10 per cent of the prison population suffer from AIDS. So far only 3 AIDS victims have been discovered in New

South Wales prisons (42). But what is to be done when a prisoner is discovered to suffer from AIDS? Is he or she to be isolated? Will the resources be available for special treatment? What will be the consequence of the exposure of other prisoners to the AIDS infection? As is well known, AIDS can be spread by sexual contact, but it can also be spread by the use of infected syringes. It is understood that condoms are available in prisons. These may reduce or eliminate the risk of AIDS from sexual contact. But how is our society to approach the recognition of drugs in prison and the great risk which some prisoners will face that, by the use and exchange of infected syringes, they are exposed to the spread of the AIDS virus? It is difficult, if not impossible, for prison authorities to sanction the use of drugs in prison by the provision of clean, disposable needles. This problem presents a true quandary. Is the reality of drug abuse in prison to be recognised? Can it be stamped out as the best solution? If it cannot, what is the consequence of condoning or acknowledging the repeated use of infected needles with the inevitable spread of the AIDS virus as a consequence to people in a dependent situation?

In the armed forces, compulsory tests have been introduced in the United States. Whether they are warranted and whether they will be introduced in Australia does not appear to have been discussed in the public media.

REGISTER PROSTITUTES

Prostitutes have been described as the 'time bomb' of the AIDS 'crisis'. Some reports suggest that they will be the vectors by which the virus is spread from the homosexual community, via the bisexual community, to the heterosexual majority. The number of Australian men said to have experienced bisexual relationships has been estimated at 20 per cent of the population. This is, then, a very large potential vector. Mr N Wran has said that he would consider registering prostitutes as a step towards control of the spread of AIDS in New South Wales (42). Meanwhile, the Australian Prostitutes Collective has distributed pamphlets to prostitutes urging the use of precaution, particularly insistence upon the use of condoms (43). Parliamentary inquiries into prostitution generally invoke outraged responses from the churches and other groups. But if prostitutes are to be a channel for the widespread penetration of the AIDS virus to the general community from the minority presently concerned, it seems likely that legal regulation directed at prostitution will need to include consideration of health tests and other steps designed to diminish the risk of spreading the infection.

CRIMINAL LAW: KNOWING OFFENCES

The introduction of criminal penalties against those who 'knowingly' spread the AIDS virus raises the question of the balance between individual claims to privacy and the rights of other individuals not to be

knowingly infected. Given the deadly character of the Category A AIDS condition, knowingly spreading that condition is obviously a cruel and anti-social act. Without the consent of the victim, it may already be a crime, a public health offence and possibly a civil wrong actionable in the courts (44). Cases have already been reported of the commencement of proceedings by victims against those who have infected them (45). So far, there have been comparatively few such cases either in Australia or even the United States. But we are likely to see many more. And as more knowledge about AIDS, the test, anti-bodies and their significance spreads in the community, the consequences of wilful conduct, neglectful of the rights of others, will attract the attention of the courts. But the criminal law of punishment and the civil law of compensation are scant redress for people who acquire a deadly condition. Even if such cases can be brought before the court in time, ie before (possibly) both the victim and the culprit have died, little beneficial vindication will be secured. Much more useful may be concentration by society on prevention. Punishment or money after acquisition of the condition is small comfort to those who suffer.

Low key approach

CONDOMS AND 'SAFE SEX'

Because AIDS is carried by body fluids, particularly blood and semen, a great deal of attention has been paid to promoting the availability of condoms. According to a recent poll (46) 56 per cent of Australians think that condoms should be on sale at supermarkets. There would be some church and other opposition, concerned about the impact on the young. But this impact must be weighed against the need for protection of the young who remain the most sexually active and therefore the most at risk. The need for legislation to permit the sale at supermarkets and then the need to encourage stores actually to carry the product requires the attention of health agencies. The recent announcement in New South Wales of the intention to change regulations to permit the use of automatic vending machines for the sale of condoms in public toilets and other places of common resort is an inevitable consequence of the recognition that 'Captain Condom' may be the chief practical weapon in the war against AIDS, at least until a vaccine is developed (47). The free availability of condoms in places of potential sexual encounter and provision of literature on the utility of condoms are necessary to overcome: the fatalism of some who suspect they may already have the condition; the resistance of others to the change of sexual activity fundamentally important to their identity, and self esteem and the resistance that is said to exist in some quarters to the use of this barrier to intimate contact. Yet the resistance must be overcome by education. Social policy and the law must give a high priority, as it seems to me, to promoting the use of the condom and to explaining so called 'safe sex'. As the AIDS Task Force has said, unless sexual habits can

be changed – something that is extremely difficult to achieve – there will continue to be a high toll (48). Fortunately, the decline in the incidence of AIDS in Australia recently reported suggests that the education campaign may already have had some success.

PASS CARD

One recent report has suggested the development in the United States of a card which indicates that a person is free of the AIDS virus. It is reported that personal advertisements boast that the advertiser is anti-body negative. But as Dr Blewett has pointed out, such cards and boasts may be of little use, being 'spent' upon their first encounter if the other partner brings contact with the AIDS virus. The whole notion of such a 'pass' seems ineffective to me.

BLOOD TRANSFUSION AND TRANSPLANTS

In a number of countries, including Australia, steps have been taken to introduce protections against unintended introduction of the AIDS virus through blood transfusion or organ transplants (49). Amendments throughout Australia have introduced offences to discourage the donation of blood by people at risk of AIDS. Perhaps more importantly, the introduction of screening agents has reduced the risk of unintended cross-infection. But questions remain. One such question recently came before Master Allen in the Supreme Court of New South Wales. A victim of AIDS, allegedly suffered by reason of blood transfusion, sought the identification of the name of the donor. This was denied by Master [Deputy Judge] Allen (45). He said it would betray the privacy of not only the donor in question but of all blood donors. In the United States, as in Australia, there are several cases where blood banks are being sued. The liability of manufacturers and distributors of blood products is already the subject of numerous law review articles (50).

OTHER MEASURES

There are many other legal measures which should be mentioned. They include a New York proposal that all applicants for a marriage licence be required to undergo the AIDS test and that the law should forbid discrimination by insurance companies on the grounds of AIDS. Time does not permit the exploration of these questions.

Law keep out!

Finally, there are those who urge that the law should keep out of this problem. They contend that it is a public health issue which requires novel and supportive public health responses not laws. These responses should be compassionate for the victims and should remember that they are the principal sufferers who need the support of society and of its infrastructure. Often they are even more in need of such support because of the lack of family support

upon which other victims of earlier epidemics could draw.

Upon this view, the proper approach is to do nothing at all that discourages people from seeking the test. Education, including in the classroom, is said to be the best and most effective response – far more likely to contain the spread of the AIDS virus by explaining 'safe sex' than by relying on the dimly perceived risk of criminal punishment or civil action. These are, after all infinitely less frightening, contemplated in potential, than the acquisition of the terminal condition itself.

Given that the high-risk groups are already accustomed to discrimination, alienation and isolation, the introduction of punitive measures, compulsory reporting and criminal offences may be seen as just the latest 'backlash' of a prejudiced society. This feeling is encouraged when it is accompanied by legislation, such as has been enacted in the Liquor and Other Acts Amendment Act 1985 No 81, S23, in Queensland, forbidding the sale of alcohol to 'perverts' and 'deviants'. Only two States of Australia have anti-discrimination laws providing an avenue of redress to homosexuals. These are New South Wales (51) and South Australia (52). In the US in response to growing evidence of discrimination against homosexuals generally and victims of AIDS in particular (53), proposals have been made in some places for new laws to give added protection to the victims of AIDS. The object of a Los Angeles bill, unanimously adopted by the City Council (54) is to forbid and redress discrimination against AIDS victims (55).

Some commentators are urging that it is necessary to attack the basic causes of alienation and self-deprecation which promote unhealthy life-styles amongst homosexuals. There is some evidence that, despite the setback caused by the AIDS problem, progress continues to be made in some quarters. For example, the recent announcement by the Federal Minister for Immigration of more tolerant approaches to claims by persons with steady homosexual relationships for immigration visas, represent a step in the direction of promoting (or at least not destroying) the chance of monogamous relationships rather than multiple-sex partners. The latter bring the risk of infection and cross-infection. All too frequently, in the law, we attack symptoms and not the underlying issue. If the underlying issue is prejudice, stereotyping and discrimination against particular groups in our community, we must be on our guard lest the AIDS problem should be blown out of proportion and result in turning the clock back, making the homosexual population (and apparently a large bisexual population) the scapegoats – just as the Chinese were made the scapegoats in the smallpox outbreak in Sydney of 1881 and the plague outbreak of 1900. Consensual adult homosexual conduct is still illegal in some parts of Australia. This situation, obviously in the process of being reversed, is one of the causes of alienation. It is very difficult in those jurisdictions where consensual conduct between adults is unlawful

(and liable to stigmatisation and severe penalties) for authorities to confront the spread of AIDS with success. For success depends upon winning the confidence and securing the co-operation and trust of that group in the community which is most at risk. It is at risk not only as to itself but as to all members of the community. Therefore, the importance of winning trust and securing co-operation cannot be overstated. It is in everyone's interests – especially potential victims, both homosexuals and heterosexuals.

A great contribution must be made here by the media. Some self-restraint is called for. Generally speaking, the media's coverage of the AIDS predicament has been responsible. There have been some notable exceptions. The danger of irresponsible media coverage does not have to be judged by reference to the public hysteria and alarm that occurred in the epidemics of the 19th century. One person recently contacted a doctor, trembling with fear, because she had been in a swimming pool with a homosexual five years previously and was petrified that her punishment would be infection with AIDS (55). Irresponsible journalism can inflame such public passions. It can propel politicians into rash and counter-productive action. It can isolate the group whose full co-operation is necessary to reduce the risk to them and to the whole population. And it can promote needless fears and anxieties amongst good citizens – just for the sake of a cheap headline or a superficial, alarmist programme. The issue of AIDS is bigger than that. It deserves restrained and compassionate attention from all of us.

It is no good talking about freedom, democracy and the Australian way of life if, (56), when we are put to a test, we are neglectful of the civil rights of fellow citizens and foolish, ill-considered, ill-directed and inefficient in our legal responses to an important challenge to public health. There is no doubt that the AIDS virus will test the skills of our scientists, the compassion of our health workers, the balance of our politicians and the restraint of our population. The need for balance and restraint is the lesson that is taught to us by reflection upon the melancholy response of our society to earlier crises of this kind. Let us hope that this time, we do better.

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